# DRVD
# CONFIDENTIAL REPORT

# AN INVESTIGATION INTO THE ALLEGED ABUSE OF GJ

## Thirty-three year old female patient at Southwestern Virginia Mental Health Institute ("SWVMHI") alleges she was physically abused by staff and subjected to unnecessary seclusion and restraint.

## DRVD CASE# 98-0100 M
## Department for Rights of Virginians with Disabilities
## Staunton Field Office
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## I. INTRODUCTION

This is a summary of the findings of the investigation by the Department for Rights of Virginians with Disabilities ("DRVD") into the alleged physical abuse of GJ, a thirty-three year old female patient at SWVMHI, by a SWVMHI staff person.

GJ reported to DRVD that a SWVMHI staff person had injured her left hand while forcing her to hang up the telephone so that she could be placed in restraints. GJ had been involved in a physical altercation with another female resident a few minutes earlier.

DRVD conducted this investigation pursuant to the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 *et seq*.). The investigation included a review of the following:

1. GJ's medical records from SWVMHI;
2. X-Ray of GJ's left hand;
3. Interviews with SWVMHI staff regarding the incident;
4. Interview summaries from Preliminary Assessment conducted by SWVMI staff;

5. Preliminary Assessment Report completed by SWVMHI staff;
6. Recommendations made by Smyth County Department of Social Services, Adult Protective Services Division regarding the incident.

## II. BACKGROUND

### A. The Facility

SWVMHI, located in Marion, Virginia, is an inpatient psychiatric facility licensed and operated by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services ("DMHMRSAS"). The facility is accredited by the Joint Commission on Acceditation of Health Organizations ("JCAHO") and provides diagnosis and treatment of mental disorders for adults.

### B. The Patient

GJ is a thirty-three year old female with a history of Schizoaffective Disorder with hallucinations and episodic periods of psychosis. She was admitted to SWVMHI in September 1996 due to increased agitation and delusional ideas, following her assaultive behavior towards staff at the home for adults where she had resided for several months.

GJ's medical record indicated that she had been hospitalized at a private psychiatric hospital in the past. This was her first admission to a state mental health facility. The record also indicated that she was delusional and hostile at times, and responded to auditory hallucinations. Although GJ had exhibited outbursts towards staff and other residents on prior occasions, the use of seclusion or physical restraint had not been necessary to control these behaviors.

GJ's medical record indicated that her medications at the time of this incident were as follows:

1. Seroquel 150 mg. qam and 200 mg. qhs
2. Lithium 900 mg. bid
3. Depakote 1000 mg. qam, and qhs, 500 mg. at noon
4. Ativan 2 mg. every 4 hours PRN

## II. FACTS SURROUNDING THE INCIDENT

### A. Interviews Conducted During SWVMHI Preliminary Assessment

1. Interviews with GJ

GJ was initially interviewed on May 6, 1998 by the SWVMHI investigator. GJ stated that on May 5, 1998 another female resident ("JR") had hit her in the stomach and shoved her backwards. Later that day, GJ had gone to the laundry room to get her clothes and when she returned to her room she found the female resident going through her clothes. She had told the staff two times that day that the female resident had been in her room and that she was "going to get her out of her room." GJ told her to "get the hell out of her room" but she refused. GJ grabbed the female resident by the shirt with both hands and threw her out of her room. GJ stated that the female resident fell onto the floor.

She said that at that time, the male Psychiatric Aide ("LW"), the male Ward Registered Nurse (" MB"), and a female Psychiatric Aide came to check on the female resident in the hallway, who "had a little bit of blood on her lip." GJ then went to the pay phone to call "that 1-800 number where patients are not to be neglected." Psychiatric Aide LW grabbed the phone and said, "you aren't going to call anyone." Psychiatric Aide LW and Registered Nurse MB dragged her down to the floor. Registered Nurse MB grabbed her fingers and pulled back. Psychiatric Aide LW had her head back. "The (Registered Nurse) had me down on the floor like he was going to rape me, so I kicked him in the (groin). I was trying to get up." GJ stated that her fingers were hurt before she went into seclusion and restraint. While being restrained she told the staff that her fingers hurt and they loosened the restraints on the left hand. "My fingers looked this way when I got out of restraints. They did an x-ray today." The investigator noted that GJ's knuckles and the area between her fingers on the left hand were red, blue, and swollen.

GJ was re-interviewed on May 7, 1998. GJ stated that another female resident had been in her room going through her clothes. GJ told her to stop and to get out, and the female resident refused. She took the female resident by the shirt with both hands and threw her out of the room into the hallway where she landed on her side and cheek. GJ said that Registered Nurse MB and Psychiatric Aide LW bent her hand back and hurt it. During the interview, "bruising, blue in color, to inside

between fingers" was noted.

GJ was interviewed again on May 11, 1998 by the SWVMHI Investigator, who noted in the interview summary that GJ was "obviously chemically restrained, very slow, not able to follow questions, difficulty in responding." She also had a bruise on her left wrist, which had not been seen before, which was "a greenish yellow color indicating an older bruise, like the ones on her fingers." GJ stated that she had "gone to the phone dialed 1-800, or going to call my dad to come get me." Psychiatric Aide LW grabbed the phone and said, "you aren't going to call anyone." He squeezed her wrist (GJ pointed to the bruise on her left wrist) and she let go of the phone. When asked how her hand was injured, she stated that Psychiatric Aide LW and Registered Nurse MB did it. GJ denied the injury occurred at the payphone or that it was from hitting the female resident.

2. Interviews with the Registered Nurse

On May 6, 1998, the day after the incident, the Registered Nurse ("MB") was interviewed regarding GJ's complaint. He stated that just "a few minutes" prior to the seclusion episode with GJ, he had given a PRN medication to another female resident ("JR") and had taken her to her room. He stated that later "a door slammed" and he observed resident JR lying on the floor outside of GJ's room with blood on her upper lip. He then followed GJ to the payphone, accompanied by Psychiatric Aide LW. GJ was making a call and he told her that she needed to go into restraints for awhile. GJ walked to the door of the seclusion and restraint room without any problems, but when he told her she would have to give up her purse she went "berserk" and began kicking him and knocking him to the floor. Registered Nurse MB said that he "got GJ's legs" and that Psychiatric Aide LW was "behind her with her in a one-man hold." They then picked GJ up and put her on the bed in four point restraints. Later in his interview, he noted that "GJ got more upset at the payphone when they told her to put the phone up and that she would have to go into restraints."

During a second interview conducted on May 12, 1998, Registered Nurse MB stated that he had heard a door slam and that he noticed a female resident on the floor. He went to check the female resident and took her to the nursing station. While he was taking care of the female resident, GJ went to the payphone. After attending to the female resident, Registered Nurse MB approached GJ at the payphone and asked her what happened. GJ told him that the female resident was

"messing in her stuff." Registered Nurse MB described GJ as upset but not loud. GJ had the receiver to her ear, and Registered Nurse MB informed her she needed to go into restraints for awhile. GJ replied "You're trying to keep me from being discharged." Registered Nurse MB was unsure who hung up the phone, stating there was "some resistance" and he "may have taken it out of her hand." Psychiatric Aide LW was present at this time and assisted Registered Nurse MB in escorting GJ to the seclusion and restraint room. Registered Nurse MB was on GJ's right and Psychiatric Aide LW was on GJ's left. They entered the seclusion and restraint room and GJ became more upset when asked to leave her purse. Registered Nurse MB reached down to take the purse from GJ and put it on the floor and GJ kicked him 10 to 12 times. Registered Nurse MB saw Psychiatric Aide LW "put a hold on" GJ, then he got up and they lifted GJ onto the bed. Registered Nurse MB "was unable to identify a way (GJ) could have injured her hand."

3. Interviews with Male Psychiatric Aide

   The male Psychiatric Aide ("LW") involved in the alleged abuse was interviewed by the SWVMHI Investigator on May 7, 1998. He stated that after learning that an allegation of abuse had been made against him, he left the hospital on May 6, 1998 because "I didn't want to be in double jeopardy." He explained that if he had gone to another ward to work, someone there could make allegations and he might lose his job.

   Psychiatric Aide LW stated that on May 5, 1998, after he and a female Psychiatric Aide had taken female resident JR back to her room, GJ came out of her room cursing and went to make a telephone call. He and Registered Nurse MB went to the telephone and then they walked GJ to seclusion. Registered Nurse MB told GJ that she was going into restraints. He stated that everything was okay until Registered Nurse MB asked GJ for her purse. Psychiatric Aide LW said that he was inside the restraint room taking the bags off the cuffs and GJ had Registered Nurse MB on the floor beating on him. Psychiatric Aide LW jumped over the bed hitting his pelvis on the edge of the bed. He said that GJ was in the floor and that he used a hold "but I didn't use the correct MANDT hold." He said he was on the right side of GJ and "I wrapped one around her waist, picked the other hand up and pulled it up to the back of her head." They then lifted GJ and put her in restraints.

   He reported that when GJ gets upset she goes to her room until she is calm. He also stated that there was not enough staff to look after the

basic needs of patients and carry out requests of treatment teams. There was not enough staff to take female resident JR to a "quiet room" on another ward.

During a second interview on May 12, 1998 Psychiatric Aide LW stated that after GJ threw the female resident out of her room, he asked GJ to go to the dayroom. He said that GJ went "fussing and cussing." He and Registered Nurse MB went to talk to GJ at the phone and that GJ slammed the phone down. The three walked to the seclusion and restraint room. GJ was cursing but offered no physical resistance. Upon entering the room Psychiatric Aide LW began taking the bags off the restraints and heard a yell. When he turned to look, he saw Registered Nurse MB on the floor with GJ kicking him. Psychiatric Aide LW stated that he "achieved a hold on GJ" from the right side, "she struggled for a few seconds" and then was assisted to the bed. While in seclusion and restraints, GJ overflowed the bedpan and was provided the opportunity to go into the bathroom and change her clothes. He was not able to identify how the injury to GJ's left hand may have occurred.

4. Interview with other Registered Nurse

   Another Registered Nurse who was working on GJ's unit during the incident was interviewed. She stated that she was giving medications that day and that she saw Psychiatric Aide LW and Registered Nurse MB talking with GJ, then walking her down the hallway towards the seclusion and restraint room. She noted that GJ "did not appear to be struggling or upset." Next she heard staff yelling for help. When she got to seclusion, she saw Psychiatric Aide LW on GJ's right and Registered Nurse MB on GJ's left. She assisted in placing GJ on the bed. She saw nothing unusual and GJ made no comment about any injury.

5. Interview with GJ's Ward Psychiatrist

   GJ's psychiatrist was interviewed on May 7, 1998 and stated that he believed GJ's hand was injured as a result of her hitting the female resident, although this was not witnessed by anyone. He stated that he believed she hit her with her right hand.

## B. Additional Interviews by DRVD

1. Interview with GJ

   GJ told DRVD that on May 5, 1998, another female resident was in her room going through her belongings. She told the female resident to get out of her room. When the female resident failed to leave her room, GJ took her by the shirt and physically threw her out onto the hallway floor. GJ said the female resident landed face down and had blood on her lip.

   GJ said that she felt calm after this incident and walked to the ward payphone to call her father. She said that a male psychiatric aide was "charging at her" as she walked down the hallway to the payphone and she knew that staff were going to want to put her in restraints for throwing the female resident out of her room. While she was attempting to make her phone call, Psychiatric Aide LW grabbed her left hand and bent her fingers back from the receiver. She told him that she had the right to use the phone, but he repeatedly told her to "hang up the phone, hang up the phone." She said that Registered Nurse MB approached her and grabbed her other hand and then assisted Psychiatric Aide LW in escorting her to the restraint room.

   GJ said that when she got to the doorway of the restraint room she thought she heard Registered Nurse MB say he was going to rape her. She responded by kicking him in the crotch. There was a struggle between her and the staff and staff members were on top of her. GJ said that she was calm after the incident with the female resident and while walking to the payphone, and she could not understand why staff wanted to put her in restraints.

2. Interview with Male Psychiatric Aide

   The Psychiatric Aide LH stated that Registered Nurse MB authorized restraints for GJ based on her behavior with another female resident. Psychiatric Aide LH said that when he approached GJ to escort her to the seclusion and restraint room, she hung up the payphone herself and that he did not bend her fingers back. He said that he believed GJ's injury was the result of her hitting the other female resident in the face while throwing her out of her room, because of the blood found on the female resident's mouth.

3. Interview with Female Psychiatric Aide

A female Psychiatric Aide who assisted with the restraint of GJ was interviewed by DRVD. She stated that she had not seen GJ at the payphone earlier. She said that she first noticed GJ when she heard a "commotion" near the restraint room. She said that when she went to the restraint room she saw Psychiatric Aide LW holding one of GJ's arms. She said that she immediately grabbed GJ's legs and assisted with restraining GJ to the bed. She stated that GJ began to complain about an injury to her hand the next day.

## C. Documentation Regarding Use Of Seclusion and Restraint

GJ's medical record contains a "Nursing Initiation Form for Seclusion or Restraint," dated May 5, 1998, completed by Registered Nurse MB, who initiated the use of restraints for GJ. Registered Nurse MB documented the need to initiate restraints as follows:

1. Precipitating Behaviors exhibited: Became aggressive with staff when informed about need to be in restraints to gain control of behavior.
2. Prior Interventions/Least restrictive alternative attempted by staff: Informed about need to go to restraints to calm down.
3. Describe behavior(s) that clearly demonstrate the patient's need for protection from injuring self or others: Became aggressive towards staff when going into restraint room.

At 1:30 PM, GJ was placed in four point (wrist and ankle) restraints to the bed with constant observation by staff. Her circulation was checked and noted to be adequate and she was in no distress. GJ was given a PRN dose of Ativan 2 mg. at approximately 2:00 PM by Registered Nurse MB, after being placed in restraints. There was no documentation that staff attempted any other interventions or less restrictive alternatives prior to placing GJ in restraints.

A "Seclusion and Restraint Form," dated May 5, 1998 was completed by GJ's physician at 2:15 PM. This form also indicates that Registered Nurse MB initiated the use of restraints for GJ on May 5, 1998 at 1:30 PM. GJ's physician documented the clinical justification for the use of restraints as: patient became involved in conflict with another resident and pushed her out of the door (endangering patient). She admitted to this behavior, states she explodes in anger. Interviewed in restraints and PRN given which she took by mouth.

The physician documented that the use of restraints was limited to four hours with constant observation by staff and that GJ could be released earlier if the ward nursing staff felt that GJ had her anger under control. However, there was no documentation of the current behaviors of GJ which necessitated continued use of restraints.

The record documents that at 2:00 PM, GJ's physician talked with her in the seclusion and restraint room regarding her need to talk with staff concerning problems with other residents on the ward. Registered Nurse MB checked GJ's circulation at 2:00 PM and found it to be adequate, and he gave GJ a PRN dose of Ativan. Neither the physician nor Registered Nurse MB recorded any observations regarding GJ's current emotional condition or behaviors.

The medical record documents that at 2:45 PM, GJ voided and overflowed her bedpan. She was released from restraints and allowed to change her clothing in the bathroom, then returned to four point restraints. The record noted that GJ would continue to be monitored in four point restraints "until behavior under control." However, there was no documentation of any negative or assaultive behaviors during the time that she was out of restraints.

Although constant observation of GJ by nursing staff was ordered, the medical record contained no "Observation Record Form" or other documentation regarding the on-going monitoring of her condition. She was released from restraints at 3:45 PM, at which time she was noted to be quiet, calm, and cooperative. GJ spent a total of two hours and fifteen minutes in restraints.

## D. Medical Reports Regarding Injury to GJ

On May 6, 1998 at 8:40 AM, GJ's physician ordered an x-ray of her left third and fourth fingers due to swelling and bruising. The x-ray report completed on May 6, 1998 by the SWVMHI radiologist, documented that there was soft tissue swelling but no acute fracture was seen. The SWVMHI Medical Director, at the request of the SWVMHI facility advocate, examined GJ's left third and fourth fingers on May 7, 1998 and reviewed the x-ray of her left hand on May 8, 1998. His Physician Progress Note states "unsure of mechanism of injury, however, since only volar aspect of involved joints show injury, suspect blunt injury to volar aspect of fingers."

## III. OTHER INVESTIGATIONS

### A. SWVMHI Preliminary Assessment

A Preliminary Assessment was completed by SWVMHI on May 12, 1998 in response to GJ's allegation that on May 5, 1998, she was physically abused by two male staff persons while being placed in restraints. The Preliminary Assessment found that there were injuries to GJ's left fingers characterized by bruising, swelling, and discoloration. The Preliminary Assessment documented that the method of injury was undetermined and the person responsible was unknown.

It is noted in the SWVMHI Preliminary Interview Summaries that the SWVMHI Director contacted the Medical Director to discuss his findings. It was further noted that GJ's injury was not consistent with reports by staff of how the injury occurred. The summary indicated that: injury to underside of hand most likely to come from palm side toward point of contact; fingers were grabbed back and hyper-extended or bent backwards; or falling front side down using hand to catch self in fall.

### B. Smyth County Department of Social Services ("DSS") Investigation

DSS also investigated GJ's allegation that on May 5, 1998 she was physically abused by two male staff persons. This investigation did not determine the cause of GJ's injury. However, DSS found that SWVMHI staff improperly used restraints regarding GJ's situation,stating:

> The investigation revealed that following a confrontation between two patients, the supervising nurse made the decision to place (GJ) in the restraint room without exploring a less restrictive intervention. At the time the decision was made for the use of restraints, (GJ) was calm and not jeopardizing her safety or the safety of others.

DSS sent a letter to the SWVMHI Director on June 30, 1998 requesting a formal written response regarding the corrective actions to be taken to ensure that the situation did not recur in the future. DSS received a telephone call on August 13, 1998 from SWVMHI advising that the facility was providing additional training for staff regarding the use of restraint and handling aggressive residents. There was no formal response to DSS by SWVMHI.

## IV. FINDINGS AND CONCLUSIONS

The Department for Rights of Virginians with Disabilities finds that on May 5, 1998, GJ was subjected to excessive force by SWVMHI staff while being placed in seclusion and restraints, resulting in a soft tissue injury to the wrist and fingers of her left hand. DRVD further concludes that SWVMHI staff subjected GJ to improper and punitive use of seclusion and restraint.

The decision to place GJ into restraints was based upon her past conduct in shoving another resident, not because she posed a current threat to her own safety or to the safety of others. GJ had left the vicinity of the incident and was at the payphone trying to make a call when she was approached by the ward Registered Nurse and male Psychiatric Aide and told that she would have to go into restraints for pushing another female resident out of her room earlier. The telephone receiver was forcibly removed from her hand, resulting in injury to her wrist and fingers. Despite this, it was reported that GJ was not struggling or loud as she was escorted down the hallway, and becoming upset only as she entered the seclusion and restraint room. She was placed in four-point restraints at 1:30 PM. At 2:45 PM, she was released from four-point restraints, her clothing was changed, and she was then placed back into four-point restraints. There is no evidence that GJ was "out of control" or presented a risk of harm to herself or others at this point.

SWVMHI staff failed to comply with the procedures outlined in Hospital Policy Number 3033, *"Emergency Use of Seclusion and Restraint."* Not only is there no documentation of the legitimate therapeutic need for restraints, there is no evidence that alternate means to de-escalate her behaviors were even considered. The "Nursing Initiation Form For Seclusion Or Restraint" completed by the ward Registered Nurse documents two bases for the restraint of GJ: The earlier incident with female resident JR, and GJ's resistance to the imposition of seclusion and restraint. The use of restraint as punishment for past conduct is clearly improper and violates the human rights of the patient. It also defies logic that a patient's reaction to being placed in restraints could serve as a basis for initiating the restraint. SWVMHI failed to employ any lesser restrictive alternatives, such as the use of redirection, time out, or PRN medications. GJ spent two hours and fifteen minutes in restraints unnecessarily, and received no immediate medical attention for the injury to her wrist and hand.

## V. RECOMMENDATIONS

DRVD makes the following recommendations based upon the foregoing findings and conclusions:

1. SWVMHI staff shall properly assess and document the necessity for initiation of seclusion or restraint in accordance with SWVMHI Hospital Policy Number 3033, *"Emergency Use of Seclusion and Restraint,"* and accepted clinical standards. Staff must clearly document that all alternative means to de-escalate patient behavior were considered and lesser restrictive interventions undertaken.
2. SWVMHI shall ensure that all direct care staff are trained regarding the emergency use of seclusion and restraint at initial orientation and at least annually thereafter.
3. The Commissioner of DMHMRSAS must ensure that appropriate disciplinary and remedial action is initiated against any DMHMRSAS employee who fails to strictly adhere to policies and practices intended to protect the human rights of patients in DMHMRSAS facilities.
4. The Director of SWVMHI should report to the appropriate criminal investigative authorities, all allegations of patient abuse by an employee when there is substantiated physical injury to the patient.
5. SWVMHI Hospital Policy No. 3033, *"Emergency use of Seclusion and Restraint"* should be revised to require that any use of seclusion and restraint be immediately reported to the DMHMRSAS Human Rights Advocate assigned to that facility.

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